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ABSTRACT

To determine the extent of perceived mental health problems and the adequacy of services in a six-county area of West Virginia, a questionnaire was mailed to a sample population selected from voter registration lists, the number in the sample from each county proportionately determined by the counties' total population. The conclusion that delivery of mental health services differed widely between an area with a community mental health center and a similar area geographically contiguous, though problems in the two areas were perceived as similar, was based on a fifteen percent response to the questionnaire. The number of persons seeking professional assistance for emotional problems exceeded national averages. A majority of the population surveyed knew of someone who had sought professional assistance for emotional problems, and general hospitals and State hospitals were the most frequently used facilities by those seeking help. Assistance was provided by psychiatrists and physicians. Juvenile deliquency was cited as the most frequently noted mental health problem in the centrol area, but drug abuse was cited in the study area. The Community Mental Health Center rated a vote of confidence from residents in the study area. (AG)

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ABSTRACT: A catchment area served by a community mental health center and a similar geographically contiguous area were assessed by questionnaire as to extent of mental health problems and adequacy of services. Results suggest that while problems are perceived as similar in extent between the two areas, wide differences were reported in the delivery of mental health services. The population without local access to comparable services felt that delivery deficiencies existed but the catchment area considered their needs met more adequately. The mental health center was found to contribute significantly to the total mental health service of the area.

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A SURVEY OF MENTAL HEALTH PROBLEMS AND PROFESSIONAL SERVICES:

A Model for Evaluation of Community Mental Health

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If Community Mental Health Centers are to meet the goals projected for them one decade ago, it is important to couple evaluation with the delivery of professional services. Documentation of the number of persons in need of mental health services are elusive, but, national statistics (Coleman, 1964) indicate "mental illness" effects one out of ten Americans. According to the Joint Commission on Mental Illness and Health (1961), nearly one person in four reported that he had experienced a problem in which professional help would have been useful. One out of seven had actually sought help of some kind for past problems. This type of information may have prompted President Kennedy in 1963, to call for "a bold new approach" in the treatment of mental health problems. This ultimately resulted in the establishment of about 500 Community Mental Health Centers across the U.S., of which the Community Mental Health Center, Region II, Huntington, W.Va. is an example.

Region II is comprised of Cabell, Lincoln, Mason and Wayne Counties with a total population of 187,717 (U.S. Census, 1970). Huntington, the state's largest city, with a population of 74,315 is the urban hub for the Region II whose Northern boundry is formed by the Ohio River and the Big Sandy River (and Kentucky)to the West.

*The authors wish to thank Ada Louise Rife, Director of the Community Mental Health Center which authorized and financed this study. Special thanks is due Robert L. Boggs, Executive Director of the Region II Health Planning Assoc., Inc. and his staff for their assistance in this project.

The area has considerable rugged terrain which creates a tremendous impediment to the delivery of health services. The entire State of West Virginia is considered by the Federal Government as a poverty area and qualifies for additional funding for mental health programs. This is reflected by the amount of out-migration prevalent in the area from 1960 - 1970. During this time period the total West Virginia State population decreased by 6.2% (Region II, Health Planning Association, Inc., 1973).

A special study (Thompson, Goldsmith and Stockwell, 1965) was made for the National Institute of Mental Health of the socioeconomic ranking of thirteen states in Northeastern United States and the District of Columbia. The research, using 1960 Census data, covered all 430 counties in these states. The ranking is useful because it shows relations within the state, as well as comparison with other states. The ranking was established according to the criteria of occupation, education and income, showing that Region II and control counties score relatively low among 430 contiguous counties (See Table 1).

INSERT TABLE 1 ABOUT HERE

The presence of Marshall University in Huntington, and the relatively secure economic status of Cabell County's residents, gives that county a decided educational advantage. The other three counties in the region have severe educational problems. All four counties have a great many residents who have completed less than five years of school and may therefore be considered functionally illiterate. With the exception of Cabell, there are few college graduates in the region. Thus, only one of the counties (Cabell) exceeds both the West Virginia and the national average in school years completed by persons 25 years of age or over.

TABLE 1

SOCIOECONOMIC RANKING OF COUNTIES

Rank	County	Social Rank Scores	Rank Among 55 West Virginia Counties
1	Montgomery (Maryland)	96.7	—
...	...	...	...
150	Cabell	66.0	4
278	Mason	49.2	17
332	Putnam	43.0	33
337	Wayne	42.0	35
395	Boone	31.6	50
419	Lincoln	26.8	55
...	...	...	...
430	Buchanan (Virginia)	5.1	—

According to Hollingshead and Redlich (1958) people of lower social class have a significantly greater incidence and severity of mental illness than do those of higher social class. One may expect on the basis of the previously discussed topographic factors, census, socioeconomic and educational data, that residents of this area may incur more severe mental health problems than the national average. These factors also may interact to limit the effective delivery of mental health services. In addition, these problems have discouraged the recruitment of qualified professional staff in some specialties.

Despite these obstacles, the Community Mental Health Center is currently providing the five basic elements of service as required under NIMH guidelines. These include in-patient care, out-patient care, partial hospitalization, 24 hour emergency service and consultation and education. In addition to these basic elements of service, existing programs have been expanded and others initiated. These include a traveling satellite team, an alcoholism and drug treatment program, and consultation and education services for children.

The foregoing services and programs were projected by Phase II Staffing Application for the Community Mental Health Center and are now functioning. As intended, part of this original application anticipated the necessity for a study such as the present effort: "Evaluation will be an on-going process designed to identify the weak and strong features of the various components of the Center program and point of those aspects which may need changing." (Staffing Application for Southwestern Community Mental Health Center, Inc., 1969).

The purpose of this research was to evaluate the importance of the Community Mental Health Center in the overall program. It was hypothesized that the population of Region II catchment area would perceive mental health services as being more adequate than would the population of a geographically contiguous area without comparable services.

Method:

Pilot Study:

Prior to the study proper, a pilot study was conducted (1) to determine the adequacy of a mail-out questionnaire, and (2) to estimate probable percentage of return. Questionnaires were sent to thirty randomly sampled telephone subscribers in the Region II catchment area and of these, seven were returned within two weeks, giving a return rate of 23 percent. Based on these results, it was expected that a mail-out of six-hundred would yield a sample of approximately 150. In addition, minor modifications were made on the original questionnaire.

Sample:

Voter registration lists from Region II and from two geographically adjacent counties (Boone and Putnam) were randomly sampled. Region II has comprehensive mental health services whereas the two adjacent counties were selected as a control group having no local access to comparable services.

From a total 1970 census of the six county areas under investigation of 240,460, the fraction of each county represented was determined. In this way the sample of each county was proportionally represented.

Due to a need to expedite the study, and the lack of personnel to make door to door interviews, the mail-out questionnaire method was selected. Since no list of residents was available for our area, it was decided to use voter registration lists as the best available alternative. In addition, this would have the benefit of limiting the study to those 18 years and older. This procedure seemed adequate since the ratio of registered voters to the county population 18 years old or older ranged from 68 to 98 percent.

Questionnaire:

The objective of the questionnaire was to determine the extent of perceived mental health problems and adequacy of services.

These were conceptualized as follows:

(1) What is the type and extent of mental health problems in your area?

(2) What agency and/or professional services are utilized in meeting them?

(3) What obstacles are present in obtaining these services?

(4) What has been the impact of the Community Mental Health Center in the area served?

These general statements were expanded into specific items and arranged so as to obtain quantified responses.

Two forms of the questionnaire were designed, and designated as the long form and short form. This was necessary because items referring to the Community Mental Health Center were irrelevant to the control counties. Thus Boone and Putnam Counties received this short form. The four counties in Region II received the long form. Those items which were common to both questionnaires provided a basis for experimental and control comparisons. The remaining items of the long form provided additional information about the impact of the Community Mental Health Center service on the area it serves.

Co-sponsor:

It was felt that a less biased response to the questionnaire could be obtained if it were sponsored by an agency other than the Community Mental Health Center. Therefore the Region II Health Planning Association, Inc. was enlisted and its director agreed to endorse the project. All mail-out and return envelopes were stamped with the agency's mailing address. In addition a cover letter, using the co-sponsor letterhead was included with the questionnaire and signed by the Director of the Health Planning Association.

Results:

The overall questionnaire return percentages of 15.0 percent was somewhat less than one would expect on the basis of the pilot study which had a return of

23.0 percent. Region II questionnaire recipients responded with 16.2 percent (N = 76) returns while control counties responded with 10.6 percent (N = 14). Thus the total number of questionnaires returned was 90 out of 601 mailed out. However, the number of returns was considered adequate to represent the population sampled.

Despite national averages suggesting that one out of four persons report experiencing emotional problems requiring professional assistance, local data of a similar nature exceeded this ratio. Of those from Region II responding, 59 percent stated they knew of someone who had experienced a personal problem serious enough to warrant professional intervention; 37 percent said "no", and four percent did not respond. Of those from control counties, 86 percent responded in the affirmative, and 14 percent answered "no".

Of those people who sought help from community agencies there were some differences between Region II respondents and controls. Rank order in terms of initial contact were as follows: Region II (1) General Hospital Emergency Room, (2 and 3) State Hospital tied with Other and (4, 5 and 6) Community Mental Health Center tied with Churches tied with Family Services. Rank order for control counties: (1) County Health Department and (2,3 and 4) General Hospital Emergency Room tied with State Hospital tied with Public Welfare. For the areas combined, rankings were: (1) General Hospital Emergency Room, (2) State Hospital and (3 and 4) Community Mental Health Center tied with Churches.

For Region II respondents, the professional person considered of greatest help was, in rank order: (1) Psychiatrist, (2) Physician and (3and4) Psychologist tied with Social Worker. Rank order for control counties: (1) Physician and (2 and 3) Psychiatrist tied with Social Worker. For the areas combined, rankings were: (1) Psychiatrist, (2) Physician, (3) Social Worker and (4) Psychologist.

When one looks at the availability of mental health services in terms of geographic distances, some differences are notable between the two groups. For Region II, 44 percent live less than five miles from the nearest mental health facility and 38 percent between five and 25 miles. On the other hand, for controls, 38 percent live between five and twenty-five miles away and 46 percent more than 25 miles away.

Inquiry as to the most prevalent mental health problem yielded the following results. Rank order for Region II was: (1) Drug Abuse, (2 and 3) Alcoholism tied with "Nervous Breakdown", (4) Juvenile Delinquency and (5) Marital Problems. Rank order for controls: (1) Juvenile Delinquency, (2) Other and (3) Alcoholism. For the areas combined, rankings were: (1) Drug Abuse, (2 and 3) Alcoholism tied with Juvenile Delinquency, (4) "Nervous Breakdown" and (5) Marital Problems.

The following means may be interpreted along a common continuum which was used in the original questionnaire. Thus, according to question seven, perception of the extent of mental health problems varies only slightly between experimental and control counties. The Region II mean of 3.11 and the control mean of 3.57, both fell between Undecided and Some Extent on the five point continuum (see Table 2). A test for the difference (0.46) yielded a critical ratio which was non-significant ($t = 1.05$, $df = 88$).

Perception of the extent to which mental health needs are being served, question eight, showed a more pronounced difference (see Table 2). A t test for the difference (1.04) yielded a critical ratio which was statistically significant beyond the .005 level ($t = 10.41$, $df = 88$).

INSERT TABLE 2 ABOUT HERE

The remaining data were obtained from Region II since these referred to the Community Mental Health Center and were not pertinent to the control counties. They show differences among the four experimental counties but no formal statistical comparisons were made.

TABLE 2

SUMMARY OF REPLYS ON QUESTIONS SEVEN

AND EIGHT OF THE ORIGINAL QUESTIONNAIRE

ALONG THE FIVE POINT CONTINUUM

1	2	3	4	5
None	Slight Extent	Undecided	Some Extent	Great Extent

QUESTION SEVEN

"To what extent are mental health problems present in your community."

	Region							
	Cabell	Lincoln	Mason	Wayne	II	Boone	Putnam	Control
Mean Extent	3.16	3.0	3.2	2.94	3.11	3.66	3.4	3.57

QUESTION EIGHT

"To what extent are these needs being served?"

	Region							
	Cabell	Lincoln	Mason	Wayne	II	Boone	Putnam	Control
Mean Extent	2.96	2.8	2.8	2.53	2.83	1.56	2.2	1.79

Mean responses to the question, "To what extent are you aware of the Community Mental Health Center and its services", ranged from 2.75 to 3.0 which reflected an awareness of Center services as close to the middle of the 5 point scale. The four county means clustered about the Region II mean of 2.83 with little variability.

Similar results were obtained from Question 10, "To what extent is the Community Mental Health Center successful in meeting the mental health needs of the community?" However, a somewhat wider range and higher group mean were obtained.

Publicity of Center services was viewed lower on the continuum than any of the other issues sampled by the questionnaire. The four county means ranged from 2.0 to 2.8 while the Region II mean (2.66) was closer to the values of the other three counties.

Responses to questions twelve and thirteen were remarkably similar. The group mean response of 3.42 showed a degree of confidence in recommending Center services for one's immediate family which was virtually identical to the group mean response of 3.46 for recommending Center services to one's friends or acquaintances. This consistency also held true for each of the counties on both items.

On the final question, there was some divergence of opinion among counties concerning obstacles present in obtaining services from the Center. Lincoln and Wayne Counties reported the most difficulty, Mason the least, and Cabell close to the group mean of 2.99.

It may be noted that with one exception, all the means reported fell between 2.0 and 4.0, and clustered around the 3.0 mark on the five-point scale. This, to some extent is a function of subjects' tendency to avoid extreme responses on this type of questionnaire. Secondly, the process of averaging yields less extreme scores and finally the few unmarked items which were encoded as undecided (scale value = 3) amplified this affect. However, there was no systematic bias toward the midpoint, as an item analysis showed responses marked in the undecided category ranged from 7 to 57 percent on the various questions.

Discussion:

It may be that respondents differ from non-respondents on a mail-out questionnaire. However, a basic assumption of this study, common to research of this design, is that those who respond represent the population. Research by Eddy, Paap and Glad (1970) surveying mental health problems by interview the technique obtained a 98 percent response to the question, "Has a friend or relative had a mental health problem?", and of these 56 percent answered "Yes", 42 percent answered "No", and two percent gave no response. These data correspond closely to the results obtained in this study, and thus it can be seen that different methods furnish similar response percentages. However, in both cases the affirmative response total was considerably above the national average of 25 percent. This discrepancy may be reconciled by noting differences in the question. Whereas the national statistic refers only to the first person, the present study intended reference to either first or third person.

Of those who knew of someone who had required professional help, the two most frequently used agencies were general hospitals and state hospitals. The two most frequently cited professions providing greatest assistance were psychiatrists and physicians. This evidence suggests that the medical model of mental illness is still predominant in the thinking of the general public. This is especially thought to be true as the Community Mental Health Center was ranked following that of hospitals. It may well be that those seeking help, were in a crisis situation and sought medical facilities to ameliorate the situation, whereas those who seek Center services are not always crisis-oriented. In any case, the public appears to see a difference between hsopitals and the Center, prescriptive services by the former and preventive by the latter.

Geographic distance may be a factor in choice of facility or professional assistance for the control counties since almost half live more than 25 miles from the nearest mental health service. Thus for the controls, physicians were the most frequently sought professional while in Region II, psychiatrists were more often chosen. However, in Region II, it was found that almost half of the residents lived within five miles of some mental health service and thus had greater access to a variety of facilities and professionals.

According to Hinkle and Ivey (1969) the most frequently noted mental health problem was juvenile delinquency (30 percent). The present study also agreed with this datum for control counties (31 percent) but for Region II drug abuse was most frequently cited (35 percent). Apparently there are large similarities between the geographic areas in the Hinkle and Ivey (1969) study and Boone and Putnam (control) counties which contribute to similar results. For Region II, the metropolitan nature of Cabell County and the much publicized "drug problem" has influenced the community attitudes. Indeed, it may well be true, however, that questionnaire responses as a whole accurately reflect the seriousness of the drug problem.

For the counties combined, after drug abuse and juvenile delinquency, the most frequently cited problems were alcoholism and "nervous breakdown". These four categories of problems suggest a ripe field for mental health services and personnel. Particularly, the implications for alcoholism and durg abuse programs are clear.

When a statistical comparison was made between the Region II and control counties, it was found that there was no significant difference in the perceived extent of mental health problems. However, differences did emerge following a test of how residents judged these needs were being met. Thus, the controls, those lacking local mental health facilities, were of the opinion that serious deficiencies existed in the delivery of services. It may be that the

Community Mental Health Center, along with other agencies, provide more adequate services for Region II but the relative contribution for each agency is unknown except in the case of initial contact. It was found that Region II residents did rate success of the Center to a somewhat neutral degree. But, those of Cabell County, where the Center is located, viewed its success somewhat higher than did the three satellite counties.

This finding may dictate a need for a fuller measure of delivery of services in Lincoln, Mason and Wayne Counties or, in addition, it may point up the need for a more adequate public relations program since both awareness and impact of publicity of Center services were rated at a somewhat lower value on the five point scale than was perception of success. The relationship between publicity and awareness on the one hand, and a measure of success on the other hand may not be a simple relationship. At any rate, success of any venture is thought to follow after knowledge and experience based on use of services. Curiously enough, residents of Region II rated impact of publicity at a lower scale value than they rated any of their other responses; the solution remains the subject of future research.

Since it was found that residents of Lincoln and Wayne Counties view accessibility to Center services as somewhat hindered by red tape, it would seem that public relations in these areas would be indicated. Mason County found less red tape than Cabell County residents which suggests some differences in perceived obstacles in satellite counties. Region II, as a whole, rated extent of obstacles at the neutral point. Whether the barriers are real or supposed should be determined by further investigation.

Despite the red tape, geographic distances and other obstacles, it was found that residents of Region II had a high degree of confidence in recommending the Center services. There were virtually no differences between this confidence in recommending either an immediate family member or an acquaintance. This suggests that the Community Mental Health Center has a good professional

reputation among the population which it serves even though it is not the most frequently patronized facility.

Summary:

This study identified several mental health problems endemic to Region II, which fall within the focus of present Center programs. Among other community agencies, the Center is visable as a professional agency contributing significantly to the total mental health service of the area, in contrast to adjacent areas which have no comparable local services. Evidence also suggests that the Center image may be enhanced by effective use of a public relations program.

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